Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 11, 2014

Ms. Jane White, Administrator
Cota's Hospitality Home
1079 South Barre Road
Barre, VT 05641-8115

Dear Ms. White:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 7, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 10/21/2014
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0365	A. BUILDING: _____ B. WING _____	C 10/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTA'S HOSPITALITY HOME	1079 SOUTH BARRE ROAD BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation into multiple self-reported incidents was conducted by the Division of Licensing and Protection from 10/6 - 10/7/14. The following are regulatory findings.	R100	Please see attached Plans of correction.	
R164 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the registered nurse failed to ensure that staff was delegated to administer a specific medication for one of five residents reviewed (Resident #1). Findings include: 1. Per record review on 10/7/14, Resident #1 was admitted to the home on 8/13/14. The resident brought medications with her, including a bottle of Methadone HCL 10 mg./5 ml. Liquid, with the prescription written to take 0.5 ml/1 mg. by mouth twice daily. There was no record of the amount of liquid left in the bottle when admitted, and no controlled substance accounting sheet available in the record to indicate that the staff were measuring the medication at the change of shift. On 9/4/14, a new 30 ml. bottle was received from the pharmacy, and a count sheet was started at	R164		

R164, R167, R171 + R177 POC's accepted (see attached) 11/5/14 KCampos RN/PMC

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R164	Continued From page 1 this time. The resident's order was changed on 8/26/14 to one 0.5 ml/1 mg. once daily for 7 days, then 0.5 ml/1 mg. every other day for 7 days, then discontinue. The new bottle received on 9/4/14 would only have had three doses given from the bottle before it was discontinued, and the bottle sat in the med cart until 10/1/14, when the remainder was wasted by the two nurses and recorded as 5 cc wasted. This amount does not account for at least 23 cc/ml of the liquid Methadone that was not administered to the patient. Per interview on 10/7/14 at 1:10 PM, the Registered Nurse confirmed that the measurements of the Methadone were not recorded at change of shift on a daily basis, that staff did not fill out the controlled substance sheet properly, and that there was a large part of the Methadone bottle that was not accounted for when they wasted the remainder. The RN also confirmed at this time that staff were not delegated this particular medication administration to ensure that they were measuring the liquid properly, and recording the amount left in the bottle on the med sheet.	R164		
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or	R167		

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R167	Continued From page 2 address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that all PRN psychoactive medications given by unlicensed staff were documented with associated behaviors, time given, and effectiveness for 1 of 5 residents reviewed (Resident #2). Findings include: 1. Per record review on 10/6 - 10/7/14, Resident #2 had a diagnosis of insomnia. The MD wrote and order for" Eszopiclone (Lunesta) 2 mg, one tab by mouth at bedtime as needed for Insomnia". Per review of the June - October 2014 Medication Administration Record (MAR), the resident took the sleep aide all but two nights in June, multiple nights in July, August, September, and five times so far in the month of October. The behavior sheet associated with the administration of this medication was not filled out in October at all, and intermittently when administered in June - September. The reverse side of the MAR was not filled out by staff to indicate what time it was given, and if it was effective. There were also no non-pharmacological interventions listed to try before giving the sleeping pill. Per interview on 10/7/14 at 11:30 AM, the Registered Nurse confirmed that there was no consistent documentation in the MAR to indicate the time or effectiveness of the medication, and no documentation on the behavior sheets to indicate insomnia and whether any other interventions were attempted before giving the PRN sleep	R167		

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R167	Continued From page 3 medication.	R167		
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that documentation was consistent to indicate that the medication regime was appropriate and effective for two of five residents sampled (Resident #1, #2). Findings include:	R171		

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R171	Continued From page 4 1. Per record review on 10/6 - 10/7/14, Resident #2 had a PRN (as needed) medication for pain prescribed. The order was "Hydromorphone HCL 2 mg. One tab by mouth every 6 hours as needed for pain". Per review of the August/September 2014 Medication Administration Record (MAR), the resident was taking the pain medication. According to the initials on the MAR, Resident #1 took Hydromorphone for pain on 8/13, 8/15, 8/16, 8/20, 8/21, 8/23, twice on 8/27, and on 8/31/14. The documentation on the back of the MAR of time given and effectiveness was not filled out for all administrations in August. In September 2014, the Hydromorphone was given a total of 18 times per the initials on the MAR. Again the reverse side of the MAR was not documented with the time of administration or the effectiveness for many of the initialed doses given. Per interview on 10/7/14 at 1:10 PM, the Registered Nurse confirmed that the documentation for giving the PRN Hydromorphone HCL was not consistently completed by the staff person who gave the medication as they had been instructed to do. 2. Per record review on 10/6 - 10/7/14, Resident #2 had a diagnosis of insomnia. The MD wrote and order for" Eszopiclone (Lunesta) 2 mg. one tab by mouth at bedtime as needed for insomnia". Per review of the June, July, August, September, and October 2014 Medication Administration Record (MAR), the resident took the sleep aide all but two nights in June 2014, multiple nights in July, August, September, and five times so far in the month of October. The behavior sheet associated with the administration of this medication was not filled out in October at all, and intermittently when administered in June-	R171		

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R171	Continued From page 5 September. The reverse side of the MAR was not filled out by staff to indicate what time it was given, and if it was effective. There were also no non-pharmacological interventions listed to try before giving the sleeping pill. Also for this medication record, there were blank spots on the MAR where corresponding staff documentation stated that the resident refused medications, however staff did not initial and circle the entry with an explanation, just left blank. Per interview on 10/7/14 at 11:30 AM, the Registered Nurse confirmed that there were blank spots on the MAR that were actually resident refusals to take medications, there was no consistent documentation in the MAR to indicate the time or effectiveness of the medication, and no documentation on the behavior sheets to indicate insomnia and whether any other interventions were attempted before giving the PRN sleep medication.	R171		
R177 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that all controlled	R177		

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R177	Continued From page 6 substances were accurately accounted for on a daily or weekly basis for 1 of 5 residents sampled (Resident #1). Findings include: 1. Per record review on 10/7/14, Resident #1 was admitted to the home on 8/13/14. The resident brought medications with her, including a bottle of Methadone HCL 10 mg./5 ml. Liquid, with the prescription written to take 0.5 ml/1 mg. by mouth twice daily. There was no record of the amount of liquid left in the bottle when admitted, and no controlled substance accounting sheet available in the record to indicate that the staff were measuring the medication at the change of shift. On 9/4/14, a new 30 ml. bottle was received from the pharmacy, and a count sheet was started at this time. The resident's order was changed on 8/26/14 to one 0.5 ml/1 mg. once daily for 7 days, then 0.5 ml/1 mg. every other day for 7 days, the discontinue. The new bottle received on 9/4/14 would only have had three doses given from the bottle before it was discontinued, and the bottle sat in the med cart until 10/1/14, when the remainder was wasted by the two nurses and recorded as 5 cc wasted. This amount does not account for at least 23 cc/ml of the liquid Methadone that was not administered to the patient. Per interview on 10/7/14 at 1:10 PM, the Registered Nurse confirmed that the measurements of the Methadone were not recorded at change of shift on a daily basis, that staff did not count the liquid medication or fill out the controlled substance sheet properly, and that there was a large part of the Methadone bottle that was not accounted for when they wasted the remainder. 2. Per record review on 10/6 - 10/7/14, Resident #1 had an order for Hydromorphone 2 mg. One tab by mouth every 6 hours as needed for pain".	R177		

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R177	Continued From page 7 The resident took this medication as needed from the time of admission on 8/13/14 to the present. Upon arrival at the home, Resident #1 had a bottle of 73 Hydromorphone tablets 2 mg. they brought with them. The narcotic count sheet was set up at admission with a start count of 73 tabs. The daily count was off by one tab on 8/20 and 8/25/14. On 9/1/14 there was also a discrepancy of one tablet missing. Between 9/8 and 9/9/14, there were 4 pills unaccounted for per review of administration records. On 9/10/14, the count went from 47 pills to 42 pills, without documentation that it was given to the resident. On 9/12/14, the Hydromorphone pills went from 42 pills to 29 pills, without any explanation. On 9/15, the count went from 28 to 15 pills, and the following day only 4 pills were counted. On 9/17/14, the count was down to zero pills left, although the day before had read 4 pills, with only one documented administration. Per interview with the home's manager, the discrepancy had been found on 9/17/14, and a newer employee was terminated after many of these discrepancies were found after they had worked the evening shift. Per interview on 10/7/14 at 2:45 PM, the Registered Nurse confirmed that the narcotic count for this medication was not done properly with two signatures of staff completing it, and that the Hydromorphone was possibly diverted, and that the method staff were using to count the controlled medications was not frequent enough or appropriately conducted to catch errors and detect any missing medications.	R177		

Cota's Hospitality Home, Inc.

1079 So. Barre Rd., Barre, VT 05641
802.479.3118
Fax: 802-479-0024

October 29, 2014

TO: Pam Cota at DAIL
RE: Plan of Correction for 10/7 inspection.

R164
Ss=D
5.10d Medication Management.

(2) Record/count sheet found: Dosage via measuring syringe was shown to staff giving med Syringe with new bottle had different measuring marks. New syringe reviewed with staff by RN and manager.
Any Medications transferred with a new Resident will be counted and reviewed by 2 staff members at time of Admission.
All unused narcotic medications will be disposed of properly within 24 hrs Of Discontinuation, Witnessed and signed off by 2 staff members.
RN and manager will be responsible to ensure staff is updated and trained on any new medications.
Staff update and Training will be done by November 30 and as needed.

R167
SS=E
5.10.d Medication Management

(5) RN and manager will monitor for completeness of documenting MAR and Behaviors sheets Weekend night staff has been delegated to review MAR and behavior sheets and list /flag where documentation needs to be completed per protocol. Started 10/18
Staff will be reeducated on proper documentation of a PRN medication and its effect and behaviors they are to be used for as indicated on Behavior sheet or MAR along with interventions to try before med if any indicated.
This will be done by RN and Manager. This will be completed by 11/15/2014

R171
SS=E
5.10g Resident has been discharged: See above plan re training /reviews that will be done to make sure proper documentation of a prn will be done.

R177
SS=E
5.10h
(5) Updated policy/procedure re narcotic count has been put in place and staff reviewed: See attatched:
RN will do weekly check count.
Any count discrepancy that can not be found and corrected at the time of count will be immediately reported to RN and or Manager.
This has been implemented.
The missing narcotic was reported and investigated per protocol: APS, Police, DAIL were all notified as well inhouse investigation was done. Employee in question was dismissed and count policy updated and implemented as noted above.

Signatures
Owner Michael Cota

Manager Jane White LPN/LB ASW